OPTIMOTION ORTHOPAEDICS

Phone 407-355-3120 | Fax 407-355-3119

Referred By:

☐ Friend ☐ Family ☐ Social Media (Google, Facebook, etc) ☐ Seminar ☐ Emergency Room

☐ Billboard ☐ Other: _____________

☐ Physician Name: _________________________________ Phone: ______________________ Fax: ____________________

Address/City/State/Zip: ____

PATIENT INFORMATION

First Name: _________________________ Middle: ______ Last Name: ________________________________

DOB: ____________________________ SSN: _______________________________

Gender ___________________ Race: __________________________ Ethnicity: ___________________________

Marital Status: _____________________ Spoken Languages: ____________________ , ______________________

Address/City/State/Zip: ____

Cell Phone: _________________________ Home Phone: ________________________

Work Phone: _______________________ Email Address: ____

Occupation: _________________________ Employer/Phone Number: ____________________________________

PRIMARY CARE DOCTOR

Physician Name: _______________________________________ Phone: ___________________ Fax: __________________

Address/City/State/Zip: ____

☐ Same as referring doctor listed above

EMERGENCY CONTACT

Contact Name: _____________________________________ Relationship to Patient: ________________________

Cell Phone: _____________________ Home Phone: ____________________ Work Phone: ___________________

Email Address: ____

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FALL RISK ASSESSMENT

Patient Name: ______________________________ DOB: ______________

1. Do you use an assisted device? (walker, cane or crutches) ☐ YES ☐ NO
2. Have you fallen within the past year? ☐ YES ☐ NO
3. Do you feel a buckling sensation? ☐ YES ☐ NO
4. Are you wheelchair or home bound? ☐ YES ☐ NO

Patient Signature: ____________________________ Date: __________________

Patient Name: ____ **DOB:** ___________________

Height: _____________________________________ **Weight:** __________________________

List ALL Medication Allergies	Reaction	Severity (none, mild, moderate, severe)

Are you a tobacco user? ☐ **Yes** ☐ **No**

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: Prescription and over the counter medications, herbals, vitamin/mineral/dietary supplement. **ALL FIELDS ARE REQUIRED**

Name of Current Medication (example: Aspirin tablet)	**Dosage** (example: 325 mg)	**Frequency/Route of Administration** (example: 3 times daily orally)	**Length of Use**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

PHARMACY INFORMATION: Please indicate the pharmacy you would like your medications sent to:
Pharmacy Name: ____
Pharmacy Phone Number: _____________________________________
Pharmacy Address: ____

Patient Name: **Date:**

Medical disorders: If you have had any of the following, Place Mark inside Circles

- ○ No Medical History
- ○ AIDS/HIV
- ○ **Alcoholism**
- ○ **Alzheimer's**
- ○ **Anemia**
- ○ **Rheumatoid Arthritis**
- ○ **Asthma**
- ○ **Blood Clot Leg**
- ○ **Blood Clot Lung**
- ○ Stroke
- ○ Cancer Breast
- ○ Cancer **Colon**
- ○ Cancer **Lung**
- ○ Cancer **Prostate**
- ○ **COPD**
- ○ **Depression**
- ○ **Diabetes**
- ○ **Drug Abuse**
- ○ Sleep Apnea
- ○ Gout
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Hepatitis
- ○ Kidney Disease
- ○ Osteoarthritis
- ○ Seizures
- ○ Ulcers, Bleeding
- ○ **Other Disease (list below)**
- ○ **Blood thinners (Coumadin, Plavix, aspirin, etc)**

Surgical History: If you have had any of the following, Place Mark inside Circles

- ○ No Surgical History Reported
- ○ Carpal Tunnel Left Wrist
- ○ Arthroscopy Left Elbow
- ○ Arthroscopy Left Shoulder
- ○ Arthroscopy Left Ankle
- ○ Arthroscopy Left Knee
- ○ Arthroscopy Left Hip
- ○ Left Hip Replacement
- ○ Left Knee Replacement
- ○ Spinal Fusion
- ○ Other Surgery (list in the box below)
- ○ Cardiac (Heart)
- ○ Carpal Tunnel Right Wrist
- ○ Arthroscopy Right Elbow
- ○ Arthroscopy Right Shoulder
- ○ Arthroscopy Right Ankle
- ○ Arthroscopy Right Knee
- ○ Arthroscopy Right Hip
- ○ Right Hip Replacement
- ○ Right Knee Replacement
- ○ Laminectomy
- ○ Fracture Surgery

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- O AIDS/HIV
- O Anemia
- O Blood Clots
- O Cancer
- O Coronary Artery Disease
- O Diabetes
- O Gout
- O Heart Attack
- O Hemophilia
- O Hypertension
- O Kidney Disease
- O Liver Disease
- O Muscle Disease
- O Osteoporosis
- O Rheumatoid Arthritis
- O Osteoarthritis

Mother Medical History

- O AIDS/HIV
- O Anemia
- O Blood Clots
- O Cancer
- O Coronary Artery Disease
- O Diabetes
- O Gout
- O Heart Attack
- O Hemophilia
- O Hypertension
- O Kidney Disease
- O Liver Disease
- O Muscle Disease
- O Osteoporosis
- O Rheumatoid Arthritis
- O Osteoarthritis

Sibling Medical History

- O AIDS/HIV
- O Anemia
- O Blood Clots
- O Cancer
- O Coronary Artery Disease
- O Diabetes
- O Gout
- O Heart Attack
- O Hemophilia
- O Hypertension
- O Kidney Disease
- O Liver Disease
- O Muscle Disease
- O Osteoporosis
- O Rheumatoid Arthritis
- O Osteoarthritis

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Psychological
- O Nervousness
- O Depression
- O Mood Changes

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	
I do not use any of the above	O		

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box